UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

REGRANEX (becaplermin)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Extensions and options_____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY

CRITERIA:

- Rule out venous ulcers and / or arterial ulcers
- Patient must be diabetic, either Type I or Type II
- Not covered for diabetic ulcers above the ankle.
- Patient must have stage III or IV diabetic foot or ankle ulcer as defined in the International Association of Enterostomal therapy guide to chronic wound staging, 1989.
- Not a benefit for patients in long term care facilities, unless that patient is admitted from home or hospital with a pre-existing diabetic ulcer of the lower extremity. LTCF must submit copy of total skin assessment report made within 24hrs of admission.
- The client must have had a documented failure on a 60 day regimen of good ulcer care that includes but is not limited to :

  1. Initial complete sharp debridement.
  2. A non-weight bearing regimen.
  3. Systemic treatment for wound related infections.
  4. Moist saline dressing changes twice daily.
  5. Additional debridement if necessary.

- The subcutaneous diabetic foot ulcer may not exceed 3cm in diameter or total surface of 9.42cm2. (Size and shape must be documented)
- Total contact casting is an available method of treatment and must be considered and rejected before Regranex is to be considered.

AUTHORIZATION:

8 weeks(15-30 Grams)

RE-AUTHORIZATION:

Documentation of 30% reduction in ulcer size must be achieved before a second prior is given.
Treatment is limited to a maximum of 60 grams of Regranex.